I

106TH CONGRESS
1ST SESSION

H. R. 1806

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide adequate access to providers of obstetric and gynecological services.

IN THE HOUSE OF REPRESENTATIVES

MAY 13, 1999

Mrs. LOWEY (for herself and Mr. LAZIO) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide adequate access to providers of obstetric and gynecological services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Access to Women's Health Care Act of 1999''.

(b) FINDINGS.—Congress finds the following:

(1) Women's health historically has received little attention.

(2) Women have a different set of primary care needs than men and providing direct access to providers of obstetric and gynecological services is an important way to address some of these differences.

(3) A majority of women view their provider of obstetric and gynecological services as their primary or sole care provider.

(4) 78 percent of women think direct access to providers of obstetric and gynecological services is very important.

(5) Access to obstetric and gynecological services improves the health of a woman by providing primary and preventive health care throughout the woman's lifetime, encompassing care of the whole patient in addition to focusing on the processes of the female reproductive system.

(6) More than 60 percent of all office visits to providers of obstetric and gynecological services are for preventive care.

(7) President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended that women should be able to choose a qualified provider, including obstetrician-gynecologists, certified nurse midwives, and other qualified care providers offered by a plan, for the provision of routine and preventive women's health care services.

(8) Providers of obstetric and gynecological services refer their patients to other health care professionals less frequently than other primary care providers, thus avoiding costly and time-consuming referrals.

(9) Providers of obstetric and gynecological services manage the health of women beyond the reproductive system, and are uniquely qualified on the basis of education and experience to provide basic health care services to women.

(10) While more than 37 States have acted to promote residents' access to providers of obstetric and gynecological services, patients in other States or in Federally-governed health plans are not protected from access restrictions or limitations.

SEC. 2. PATIENT ACCESS TO UNRESTRICTED OBSTETRIC AND GYNECOLOGICAL SERVICES..

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. STANDARDS RELATING TO ACCESS TO UNRESTRICTED OBSTETRIC AND GYNECOLOGICAL SERVICES.

''(a) IN GENERAL.—In a case in which a group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan provides benefits under the terms of the plan consisting of obstetric or gynecological services, including appropriate follow-up services and referrals for related obstetric or gynecological services, the plan or issuer shall provide for a female participant or beneficiary to designate a provider of obstetric and gynecological services who has agreed to be designated as such, as the participant or beneficiary's primary care provider. If such participant or beneficiary has not designated such a provider as a primary care provider, the plan or issuer—

''(1) may not require prior authorization by the participant or beneficiary's primary care provider or otherwise for coverage of obstetric or gynecological

services provided by a participating health care professional practicing in accordance with State law, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological services by such a participating health care professional as the prior authorization of the primary care provider with respect to such care under the coverage.

''(b) ADEQUATE NUMBER OF PROVIDERS OF OBSTETRIC AND GYNECOLOGICAL SERVICES.—Each group health plan and health insurance issuer offering health insurance coverage in connection with a group health plan shall have an adequate number of providers of obstetric and gynecological services on its roster to satisfy the health care needs of all female participants and beneficiaries who choose to have such a provider as a primary care provider, or who otherwise need the services of a provider of obstetric and gynecological services.

''(c) DEFINITION OF ''PROVIDER OF OBSTETRIC AND GYNECOLOGICAL SERVICES''.—For purposes of this section the term ''provider of obstetric and gynecological services means—

''(1) an obstetrician-gynecologist;

''(2) a nurse practitioner as defined in section 1861(aa)(5)(A); or

''(3) a certified nurse-midwife as defined in section 1861(gg)(2).

''(d) CONSTRUCTION.—Nothing in subsection (a)(2) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of obstetric or gynecological services so ordered.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to women to encourage such women to accept less than the minimum protections available under this section; or

''(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care to an individual participant or beneficiary in accordance with this section.

''(f) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering

group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) NON-PREEMPTION OF MORE PROTECTIVE STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—This section shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage that provides greater protections to participant and beneficiaries than the protections provided under this section.''.

''(h) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 714(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of such Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. STANDARDS RELATING TO ACCESS TO UNRESTRICTED OBSTETRIC AND GYNECOLOGICAL SERVICES.

''(a) IN GENERAL.—The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 714(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in this section as if such section applied to such issuer and such issuer were a group health plan.''.

(b) ERISA AMENDMENTS.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. STANDARDS RELATING TO ACCESS TO UNRESTRICTED OBSTETRIC AND GYNECOLOGICAL SERVICES.

''(a) IN GENERAL.—A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with

the requirements of section 2707 of the Public Health Service Act.

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirement of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirement apply.''.

(2) CONFORMING AMENDMENT.—Section 732(a) of such Act (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(3) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Standards relating to access to unrestricted obstetric and gynecological services.''.

(c) INTERNAL REVENUE CODE AMENDMENTS.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amend-

ed by inserting after section 9812 the following new section:

"SEC. 9813. STANDARDS RELATING TO ACCESS TO UNRESTRICTED OBSTETRIC AND GYNECOLOGICAL SERVICES.

''(a) IN GENERAL.—In a case in which a group health plan provides benefits under the terms of the plan consisting of obstetric or gynecological services, including appropriate follow-up services and referrals for diagnostic testing related to obstetric or gynecological services, the plan shall provide for a female participant or beneficiary to designate a provider of obstetric and gynecological services who has agreed to be designated as such, as the participant or beneficiary's primary care provider. If such participant or beneficiary has not designated such a provider as a primary care provider, the plan—

''(1) may not require prior authorization by the participant or beneficiary's primary care provider or otherwise for coverage of obstetric or gynecological services provided by a participating health care professional practicing in accordance with State law, to the extent such service is otherwise covered; and

''(2) shall treat the ordering of other gynecological services by such a participating health care professional as the prior authorization of the pri-

mary care provider with respect to such care under the coverage.

''(b) ADEQUATE NUMBER OF PROVIDERS OF OBSTETRIC AND GYNECOLOGICAL SERVICES.—Each group health plan shall have an adequate number of providers of obstetric and gynecological services on its roster to satisfy the health care needs of all female participants and beneficiaries who choose to have such a provider as a primary care provider, or who otherwise need the services of a provider obstetric and gynecological services.

''(c) DEFINITION OF ''PROVIDER OF OBSTETRIC AND GYNECOLOGICAL SERVICES''.—For purposes of this section the term ''provider of obstetric and gynecological services means—

''(1) an obstetrician-gynecologist;

''(2) a nurse practitioner as defined in section 1861(aa)(5)(A) of the Social Security Act (42 U.S.C. 1395x(aa)(5(A)); or

''(3) a certified nurse-midwife as defined in section 1861(gg)(2) of the Social Security Act (42 U.S.C. 1395x(gg)(2)).

''(d) CONSTRUCTION.—Nothing in subsection (a)(2) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of obstetric or gynecological services so ordered.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to women to encourage such women to accept less than the minimum protections available under this section; or

''(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care to an individual participant or beneficiary in accordance with this section.

''(f) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.''.

(2) CONFORMING AMENDMENT.—Section 4980D(d)(1) of such Code is amended by striking ''section 9811'' and inserting ''sections 9811 and 9813''.

(3) CLERICAL AMENDMENT.—The table of sections of subchapter B of chapter 100 of such Code is amended by inserting after the item relating to section 9812 the following new item:

"Sec. 9813. Standards relating to access to unrestricted obstetric and gynecological services.".

(d) EFFECTIVE DATES AND RELATED RULES.—

(1) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by subsections (a)(1), (b), and (c) apply with respect to group health plans for plan years beginning on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act.

(B) COLLECTIVE BARGAINING EXCEPTION.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made subsections (a)(1), (b), and (c) shall not apply to plan years beginning before the later of—

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the first day described in subparagraph (A).

For purposes of clause (i), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a)(1), (b), or (c) shall not be treated as a termination of such collective bargaining agreement.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendment made by subsection (a)(2) applies with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act.

(3) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with re-

spect to a violation of a requirement imposed by such amendments, and no penalty shall be imposed on any failure by such plan to comply with any requirement imposed by such amendments, to the extent that violation or failure occurs before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

SEC. 3. COORDINATION OF ADMINISTRATION.

The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy

that avoids duplication of enforcement efforts and assigns priorities in enforcement.

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